RESET

Department of Labor and Industries

This form must be completed by a vocational Rehabilitation counselor who has received a referral from a self-insured employer.

SELF INSURANCE

BOARD & ROOM COST ENCUMBRANCE

☐ **Original** ☐ **Modification**

****** Counselor is responsible for sending a copy of this form to each vendor ******

Claimant:	Date	Claim Number

Billing Category and Code	Vendor Name Provider No.	Vendor Name Provider No.	Vendor Name Provider No.	Vendor Name Provider No.	Total Funds
Board (Food & Utilities)					$0.00
Rent (Room & Furniture)					$0.00
Relocation (1 time/life of claim)					$0.00
Vendor Funds Allocated	$0.00	$0.00	$0.00	0.00	
Dates of Service	From: To:	From: To:	From: To:	From: To:	

Company	Phone No.	FAX No.

Assigned Vocational Counselor:	Date	Signature

Employer or Service Representative ☐ Approved ☐ Not Approved	Date	Phone No.	Signature

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